

**VHRI Advisory Council
May 3, 2012**

Welcome and introductions

Members of the VHRI Advisory Council in attendance:

Joe Wilson
Jane Kusiak
Monty Dise
Dr. Hamrick
Dr. Johnson
Senator M. Herring
Cindi Jones
Secretary Bill Hazel
Ed Howell
Scott Johnson
Geoff Brown
William Fralin
JoAnn Perkins (for Burke King)
Chuck Hall
Lindsay Berry (for Jim Carlson)
Delegate P. Hope
Shirley Gibson

Advisor/Participants

Senator J. Watkins
Len Nichols
Molly Huffstetler
Al Battle
Matt Cobb
Keith Hare

Secretary Hazel called the meeting to order. He welcomed all in attendance and thanked the VHRI Advisory Council members for their continued participation, noting that several new members have been appointed. Secretary Hazel stated that the Governor does appreciate their input. The report in the fall was very useful and he asked that the group continue their planning efforts. The Secretary said that at the federal level, they are not inclined to make decisions to help us, especially in an election year. If we don't pick an Essential Health Benefit (EHB) plan today from the list we have, we'll at least have a good idea of our choices for future decision-making. The October 2013 deadline is not far off so we must keep forging ahead.

Secretary Hazel next informed the Advisory Council of several new appointees to their membership (Ed Howell, Vice President, CEO, University of Virginia Medical Center; Honorable M. Herring, Member, Virginia State Senate; and Honorable R. Stuart, Member, Virginia State Senate) and identified several representatives sitting in for members who were unable to attend. Members and other attendees from around the table were then invited to introduce themselves. Cindi Jones, VHRI Director, recognized Senator Barker in the audience and invited all of the Task Force members in attendance to also introduce themselves.

Update/Status Report on VHRI Activities

Secretary Hazel asked Cindi Jones to provide an update to the Advisory Council. She advised that nine (9) bills regarding the Health Benefit Exchange (HBE) were considered during the 2012 legislative session, a number of which referenced VHRI efforts. Ms. Jones stated that public comments were very informative and helped to educate us. She expressed her appreciation all for their public input as it is critical to the work being done.

Ms. Jones advised there were to be three meetings before the Supreme Court decision. The topic for today's meeting was Essential Health Benefits (EHB) and that a panel was in place to discuss this subject. On May 24th, we will discuss the business model for the Exchange. At the June meeting, we will discuss the SHOP program as part of the Exchange, and the roles of brokers and navigators. Though it's only May, there have been a number of achievements already, in particular the Virginia Center for Health Innovation and she asked Secretary Hazel to advise on where Virginia is with the Center.

Secretary Hazel replied that the Center lives in the Virginia Chamber of Commerce and its goal is to encourage innovation in health care and health care delivery. At a recent board meeting we discussed value-based insurance design. We also spent time discussing what we want to accomplish that is measureable and how we can move the private sector through employee health plans and/or HR policies into more healthy behaviors, more appropriate use of the health care system. Recently nine large medical specialty groups made a list of tests and circumstances that should never be used; think of how powerful it will be if we would agree that we would not use those procedures in Virginia. Imagine how much we can save if we can agree to listen to the experts when they tell us we shouldn't do it; lessen harm built into the system. There will be a lot more coming out of the Center. The Center's launch is the evening of June 6, the day before the Chamber's meeting on health care reform in Virginia.

Ms. Jones advised that there were some other significant legislative initiatives at the General Assembly that moved the ball forward regarding capacity and IT. She briefly described a number of pieces of legislation: House Bill 346 by Del. O'Bannon regarding nurse practitioners as part of a multidisciplinary, patient care team; House bill 146 by Sen. Puckett regarding a Statewide pilot for dental hygienists to practice under remote guidance of a dentist; another bill regarding dental care by Del. O'Bannon addressed temporary licenses for interns, faculty, etc., to increase access to dental services. VHRI discussions helped to serve as a catalyst for some of these changes. Finally, Del. O'Bannon and Sen. Puller submitted legislation to amend the code to establish all claims database to facilitate data driven evidence based improvements in quality and cost of health care. Ms. Jones noted that there were discussions on this topic in the Technology Task Force and we deferred to the Joint Commission on Health Care since they were conducting a study on this and this legislation resulted from the JCHC study. By Dec. of this year, the Commissioner of Health is to report to the Governor and the GA regarding whether providers have executed agreements to submit data to include at least 75% of all private claims. The Medicaid Reform Task Force recommended we improve care coordination, which was in the Governor's 2011 budget, and close the geographic gap in services. Ms. Jones said she was just in Abingdon and Virginia is moving 50,000 people into managed care as well as in other areas (30,000 in Roanoke area). Foster care children are being moved into managed care as well, started in Richmond in Jan. and hope to complete in next 18 months. Two types of services Virginia is looking at are behavioral health for care coordination so children and adults are getting care at the right time. An RFP is in progress and we submitted a letter of intent to CMS for a dual eligible project that is an integrated care model under one umbrella; now accepting public comment. Other proposals are out there relating to data mining, PERM/fraud prevention, new

auditors, electronic health records by physicians and hospitals, and replacing our Eligibility & Enrollment system. Secretary Hazel added that we're building a new system across DSS and DMAS, including a new online customer portal, which enables online submission of applications and will support the Exchange. We are doing a slow rollout of the customer portal (487 applications so far) and training local DSS staff now. The next step is to replace the back office system, over 20 years old, and the RFP to replace the system is under review by CMS and OAG now. This is important because it also contains the HBE as an option, though there are other options out there as well. These efforts will lead to building an effective health benefit exchange for the Commonwealth. Ms. Jones added that the Bureau of Insurance is moving forward in planning and evaluating what they need to do regarding plan management.

Ms. Jones reminded attendees of the functions of the HBE as a web based market place that allows people to compare and buy insurance. It's for three major groups: Medicaid clients (est. 420,000), individuals (est. 100,000) and small businesses, which the Council has defined a small business as 2-50 employees. Referring to the presentation, Ms. Jones noted that CMS has divided HBE into 5 core functions: eligibility, enrollment, consumer assistance, plan management and financial management. She said that Virginia has talked with national experts about these and will get some help in addressing and applying for a Level 1 grant. We will talk more about these at the next meeting in May. The next flow chart on the screen is the diagram how we think HBE will operate at a very high level; how an application would come into the HBE and the systems interfaces that come into play in the process. She then briefly discussed the HBE timeline and the key dates. In Dec., the federal government will be working with states to determine if they will be ready to begin accepting applications in October 2013. November 3, 2014 is last opportunity for states to get establishment grants. VA will probably submit several grant applications to get the money to build the HBE.

Secretary Hazel added that a lot of details yet to be filled in and will need the Council to help. At some point, the GA will need to pass legislation. If HBE goes to a board of directors with some decision-making authority, then they may need to make fewer decisions. If it ends up going to the State Corporation Commission, then other considerations may need to be applied. As Cindi mentioned, we're working technology and the funding angles, getting things set up to apply for a Level 1 grant to get the money to build the HBE if the Supreme Court decision favors PPACA. We do have to think about contingencies. What happens if SC strikes mandate, what about if other parts are stricken, what if the whole thing is thrown out. It appears that the expectation is there will be a special session called in the middle of summer. The Secretary reassured the Council that we are doing everything we can to keep Virginia on track and are still operating on the assumption that if there is a HBE in Virginia, Virginia will be positioned to build and operate its own.

Ms. Jones asked if there were any questions about what was mentioned or in the status report.

Kusiak – asked Secretary to clarify on his statement mentioning a Board v. Bureau of Insurance. I thought we recommended a quasi-governmental agency to operate the HBE.

Secretary – there is a step between our recommendations and what the GA decides to do. It was a major topic of discussion during the session involving legislation; had bills for both ways.

Battle – clarify that the exchange would be in the SCC, not the Bureau.

Essential Health Benefits Panel

Jones – if no other questions then we will switch to the panel presentation. She introduced Sandra Hunt as the expert with PricewaterhouseCoopers (PwC) who led the work on the EHB report; then introduced other panel members Doug Gray, Nicole Riley and Nancy Davenport-Ennis.

Hunt – PwC was asked to describe the report prepared regarding the EHB and the decision that need to be made in terms of selecting the benchmark plan not only for the Exchange, but for the entire market. The agenda will include a review of the Institute of Medicine's recommendations for EHB, requirements, and mandated benefits. She provided a quick overview of the 10 EHB categories : Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care. When state makes decision on the EHB plan, all health insurance plans in the state must meet the standard, whether inside or outside of the Exchange. The Institute of Medicine recommendations tried to link the ESB to understanding of cost impact of choice of definition; states should link to premiums paid in the market today. States have flexibility in reaching their own definitions, but cost is key. HHS took those recommendations and issued a bulletin outlining the 10 options for states in terms of defining EHB:

- (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- (2) any of the largest three State employee health benefit plans by enrollment;
- (3) any of the largest three national FEHBP plan options by enrollment; or
- (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Benchmark must include all categories – what does it mean? It means the Benefits that are covered, not cost sharing; those elements are not included. To the extent state selects benchmark that includes state mandates, state must pay for the subsidy costs for those services

Secretary– question – what if state picks a small employer plan that has the state mandates?

Hunt – if state choose the state employee plan that didn't have mandates, but continued requiring that the mandates be covered, then state is responsible for the costs. If it chooses the employer plan that has previously covered the mandates, then it does not require state responsibility for costs of mandates. There is lack of clarity about what will happen in 2016, but in 2014-15 state is not responsible.

Ms. Hunt continued her presentation by returning to discussion of Virginia mandated benefits (30 mandated benefits and 6 mandated offers). Most are covered in State and Federal employee plans. Did identify that the mandate for coverage of autism spectrum disorder would have the highest potential cost impact; does not currently apply to individual and small group market. Bariatric surgery is mandated for offer but not required coverage and has a big cost impact. PwC partnered with Bureau of Insurance to survey plans previously; will need to resurvey to find/ensure the most popular plan is identified. Regarding conflicts with EHB requirement, the biggest one is maternity services that are not currently fully covered in the individual market and in some small group plans; that situation changes when it becomes a requirement.

Perkins – correction – small group plans do cover maternity. There was a rider requirement for dependent coverage prior to 7/1/2011. Coverage for dependents is not an issue any more in small group market.
Hunt – Yes, but it is still for individual market.

Ms. Hunt continued by noting that there is limited mental health and substance abuse, and vision & dental; habilitative is not clear.

Secretary – can you define habilitative services?

Hunt – definition (CA) is basically those services for young children (0-3) born with significant developmental disabilities, who need the same types of services as rehab but have to learn first as opposed to relearn/rehab.

Ms. Hunt returned to identifying potential benchmark plans, determined based on enrollment from two years prior. What happens with plans no longer offered? This is a problem to be dealt with.

Secretary – does every one agree that these 3 plans listed are the largest? Concurrence from the panel and Council.

Hunt – if state does not chose a benchmark plan, the federal government will. Where you get into issues with the largest small employer plan not having all the federal minimum requirements, then you will have to add any missing services to the plan chosen. You would look to the state or federal employee plan to get the missing benefit.

Fralin – question - is this the rule or the proposed rule?

Secretary – this was put out as a bulletin. It is the rule as best we know today.

Fralin – so we're supposed to make a decision this summer based on this.

Secretary - yes.

Hunt – unlikely to change much

Ms. Hunt returned to discussion on the slides regarding benchmark plan coverage. She noted that they did rely on SPDs taken online so could be slightly inaccurate; have not gone back to the plans to confirm as could have been updated. Looked at range of details but coverage of certain benefits could not be determined, such as habilitative services. In the report, we detailed out a comparison of potential health benefits and mandates, showing the differences and where missing. It's difficult to see here in the slide, but is available online. The important take away message is that there is not a lot of difference; did not find a lot of variation. We found most of variation was on amount of services. In choosing a benchmark plan, the definition is whether a service is covered. Ultimately when choosing a plan, it also includes the level coverage with exception of cost sharing. Example – if it has a limit (i.e., 30 patient visits), then that is part of the benchmark – cost sharing is different. So the plans provide broad coverage among the 10 EHB categories except for the following: maternity (individual only); pediatric oral and vision; habilitation and behavioral health is less clear; and autism not broad coverage as well. Specific differences exist for certain coverage: chiropractic, acupuncture and hearing aids, but do vary in their stated limits; home health, speech/physical/occupational therapies, skilled nursing facility; and age limits on early intervention services, which are really the habilitative services.

Secretary – I've just been asked to allow public radio to broadcast the meeting, so please be aware that we are now being broadcast on public radio.

Ms. Hunt concluded by noting that as states are considering benchmark plans, they are tending toward the small group plans, but that the Council will have to reach its own conclusion.

Cindi Jones introduced the next panel member, Doug Gray, Executive Director of the Virginia Association of Health Plans (VAHP). Mr. Gray began by advising that his association members are in the health care business and directly involved in health care reform. He stated that they formed a work group with VAHP members to consider the EHB. The intent of Federal Health Care Reform is to provide health care coverage to the largest number of individuals possible in the most affordable way. Virginia's Health Benefit Exchange will be a vehicle for this coverage. It makes sense when choosing a benchmark plan for the Virginia Health Benefit Exchange to choose a plan that covers all required benefits but does not add more costly benefits. It is also important to remember that the Essential Health Benefits set the minimum benefits for outside the Exchange as well, which is another reason to be mindful of cost. Mr. Gray addressed some challenges with the health reform law; e.g., subsidized coverage will require an individual to spend up to 9.5% of income to attain insurance and will be difficult for some to do. By fall of 2012, states must choose a benchmark plan from four specific options or a default plan becomes the benchmark plan. The default plan is the state's largest plan in any of the three largest small group plans. In Virginia, Anthem has two plans and Optima Health Plan has the other. Since they are virtually the same, the benchmark plan discussed is the Anthem Small Group PPO plan. Mr. Gray's organization, the Virginia Association of Health Plans, supports selecting the Anthem Small Group PPO plan to be Virginia's benchmark plan. He stated that adding additional services to those already mandated by law will have significant cost impact, making health insurance beyond reach for many.

Fralin – question – Plans will be evaluated based on compatibility but not on cost sharing – who sets the copays or deductibles and how does that work regarding selection?

Hunt – to certain extent based on the metal tiers (bronze/silver/gold/platinum) sets the value – silver is going to set the standard (70%) and will determine what the copays will be.

Fralin – who makes the cost sharing decisions, state or fed, and does the fed have to approve them?

Gray – have to be careful – the market is based on the risk and health experience can not be considered in rating – so younger may pay a little more, older a little less. There is a federal requirement that limits amount of out of pocket to \$2500 – even if you can afford to pay a higher deductible, you will not have the option.

Secretary – is there an authority; how much latitude is there?

Hunt – how that benefit plan is structured is up to the state, given existing requirement; e.g., deductibles, copay

Secretary – how do the plans compete – if Anthem is the chosen plan, how readily can others compete? Is it fairly easy for the plans to adjust coverage, to get on the same page?

Perkins – what's covered is fairly standard; it's the cost sharing that varies somewhat

Dise – if I can add, the size of the network will play a large part in decision

Secretary – perhaps we're getting off track, let's go back to Doug's presentation

Additional benefits mentioned in the PwC report should not be added. They include: applied behavior analysis, surgical treatment for morbid obesity, in-vitro fertilization, acupuncture and hearing aids. Mr. Gray stated that the General Assembly has considered and rejected mandating these benefits in the individual and small group markets. He then referenced a chart on display that shows Virginia's mandated benefits: how these mandates fit into the required coverage categories; additional benefits offered in the benchmark plan that satisfy the requirements for coverage in categories where no Virginia mandates apply; and information on additional services that will need to be offered based on federal guidance on how these services will be determined. Federal guidance is really quite clear on some things. If you have monetary limits, you have to convert to visit limits instead; has to approximate what is allowed in other categories. It doesn't have to be exact but does have to meet actuarial standards. The Anthem Small Group PPO plan offers services beyond those mandated in Virginia, including pediatric dental and vision preventive services, and coverage for Durable Medical Equipment, Lab services, Preventive and Wellness services. Mr. Gray said that since Virginia is consistently in

the top 5 to 7 states with the highest number of insurance mandates, the benchmark plan currently offers comprehensive benefits.

Secretary – just want to be clear, though things may change, you would prefer that we establish a baseline plan and then deal with changes from the fed as they come along.

Gray – the Secretary brings up an important point. We waited for federal guidance for a long time. Their guidance document was their way of punting to states to move it along, that they would revisit a year or two down the line. This concluded his presentation.

Dr. Hamrick – so the spread between plan levels, silver to gold, can float between 68-72% so the difference is not that great but you have to spread yourself across all 10 categories.

Hunt – true on the benefits design. Things like variation in quality and networks is where plans are expected to compete.

Dr. Hamrick – given the cap on \$2500 out of pocket, there's not a whole lot of play in terms of different copays, deductible, etc.

Hunt – fair amount of variation in cost sharing and what gets coinsurance or what gets a copay and what doesn't

Gray – part to the challenges is where the cost sharing hits. If you're relatively young and healthy, you may want the lower premium for higher cost sharing.

Johnson – so if you look at the Anthem PPO plan and it meets the six mandatory offers, you're saying don't elevate the offers to be part of the EHB, they don't have to offer? What about benefits outside of the benchmark and their costs?

Gray – I don't think so, once you meet baseline

Hall – not everyone with serious mental illness is on Medicaid, nor should they be. Plan design will influence what is inside/outside the HBE. I hope we have a discussion about serious and persistent mental illness and health management v. sickness management. If we start with defining a plan that influences outside products then that might force people into Medicaid to get treatment. An example of a chronic patient situation was described.

Secretary – reality is that some of this is defined by the fed; they have to give states flexibility

Hall – if EHB allows for early inexpensive, make it more appealing, we can delay expensive commitments

Secretary – I'd like to let Nancy get to her presentation. But I'd like to ask, what does parity mean in mental health?

Gray – the bottom line is, chronic disease is a huge challenge, for other than mental illness too. People will have to be able to meet their out of pocket. All folks with chronic disease will face the same problem by definition; they will take more from the system than they will ever put in. What do you do with people who enter the system for treatment and are not able to pay their portion of the cost share? It's a huge issue.

Secretary – let us come back to this. Nicole, you are next.

Ms. Jones stated that Ms. Riley had no presentation to display on screen but submitted written comments.

Nicole Riley introduced herself as the Virginia State Director for the National Federation of Independent Business, Virginia's leading small business organization representing approximately 6000 small business owners throughout the Commonwealth. The increasing difficulty in accessing affordable health care is one of the top concerns among our members (right up there with taxes) and certainly the essential health benefits package will have a significant impact on the costs associated with any plan that is offered in and out of the Health Benefit Exchange. Ms. Riley stated that she would first paint a picture of the reality facing small business owners in today's health care market and how mandated health benefits impact their chances of finding affordable health care coverage. The second part of her remarks would focus on what small businesses want regarding the essential health benefits package while

touching on the analysis done by PriceWaterhouseCoopers and comments submitted to the Task Force. The final conclusions reached by Ms. Riley are included below (her full statement is located on the VHRI website).

An essential health benefits (EHB) package must be affordable. Cost continues to be the biggest barrier for individuals and employers to obtain coverage; therefore it is critical that the basic package is affordable. The package should provide services that Virginians need to protect their health – and not coverage for every treatment we might want. An EHB package should serve as a base of truly “essential” and affordable coverage. This will allow choice and opportunity to “build up” from there while ensuring that basic coverage is affordable.

An EHB package must provide flexibility that allows consumers to get coverage suited to their needs and budget. The EHB package must allow for flexibility in insurance design, and must not dictate cost sharing arrangements that limit consumer choice.

The development of an EHB package must consider the costs to our Commonwealth associated with and resulting from the package. Taxpayer costs will greatly increase if more employers are priced out of coverage, further threatening our fiscal future. Virginia will ultimately be financially responsible for its extensive mandates so it is important now and during the transition period to examine the impact of whether the mandates allow health care coverage to be affordable.

Secretary – any questions? - You talked about the mandates and there seems to be some inconsistency; what do you not want from the list? How do we address which are bad v. which should be kept; e.g., testing for PSA for some groups is a bad idea?

Riley – several years ago, the GA attempted to do that. Some of employers were attempting to get plans to meet their particular needs; i.e., 5 employees at auto shop, all single males, do not need OG/GYN coverage Secretary – but what about if one gets married, or has a daughter with needs. Insurance is for what you can’t predict.

Fralin – define the set for small businesses that decline to offer, does it rise with level of medical inflation? Would put employers out of the market?

Riley – we have a concern about that, it might just be cheaper to pay the fine. But there are other hits as well. It’s difficult to say.

Fralin – another question - if I am in the exchange and have a certain level of benefits, but switch employers and he has benefits outside of the exchange and my deductibles have gone up. If I decide to stay in the exchange, does my employer get fined?

Hunt – no fine if not in exchange; also fines don’t apply to employers under 50 employees –at another meeting the Council will address SHOP and how to encourage employers to participate

Fralin – what is incentive to encourage wellness plans?

Hunt – there are incentives to adjust the premium down for health status but not up due to status

Secretary – we had this discussion at the Center for Health Innovation meeting recently. If you look just at health care premiums, there is probably no return on investment; e.g., no treatment for obesity. However, for large employers, when look at the entire pool of health care costs, there may be a return.

Task Force member (Marcia Drinkard) – an example, our company is in individual market and we just got a premium increase of 17.5% with a \$2500 deductible plan. We’ve looked at our bills and were told it was not due to our utilization but that the insurance company was getting ready for health reform implementation.

Secretary introduced the next speaker Nancy Davenport (National Patient Advocate Foundation)

Ms. Davenport explained that the Foundation handled over 103,000 cases last year for people with chronic debilitating or life threatening conditions. 16% of their beneficiaries are Medicaid and have household income under \$11000; the next segment of 47% under \$23000. She posed three fundamental questions to the group: affordability – is what being proposed for the EHB going to serve citizens when they become ill and have to rely on the EHB benefits; will benefits be robust enough to encourage physicians to treat EHB patients, many who already limit the number of Medicare patients; question about process - everyone we serve has a chronic illness, but the out of pocket costs are limiting. If every drug available starts with generic only, then moves to brand with tiered copayments, it will knock them out of the market. – What is the out of pocket consequence to the consumer? Her number one concern is around formularies – within the HBE, there is latitude to do less than what is currently required by Medicare (6 classes/2 drugs in each). Now have the latitude to reduce to 5 classes/1 drug. She then told a story regarding a young woman who was brought to the capital to testify about drug shortages. Due to drug shortage (doxell?) she was switched to another product and her cancer returned. We ask that this panel consider formularies – not all people respond the same to a drug – provide a platform for choice.

Ms. Davenport next referred to her slide presentation. The National Patient Advocate Foundation (NPAF) is a national, non-profit organization whose mission is to create avenues of improved patient access to health care through public policy reform at the state and federal levels. NPAF is dedicated to working with the Administration, Congress, and all levels of government to overcome challenges and find solutions that will allow for affordable, high-quality health care for all. She indicated that they generally support the federal bulletin's approach which grants states significant flexibility to establish what constitutes essential health benefits. The greatest concern that NPAF has with the Bulletin is in regard to benefit design flexibility, particularly pharmaceutical benefits:

- Permitting plans to offer a minimum of one drug in a certain category or class appears to rest upon a mistaken assumption that all drugs benefit patients in the same manner. The patient population is not homogeneous and neither is its reaction to drug therapies.
- Medicare Part D has six protected classes which allow for patients to choose the drug that benefits them therapeutically, and which can be effectively tolerated. The decision to allow plans to offer a minimum of one drug in a certain category or class appears to be inconsistent with PPACA language that states the scope of the essential health benefits should be equal to the scope of benefits provided under a typical employer plan. To assure patient access to necessary pharmacologic therapies, the plans should be required to mirror the benchmark's formulary or adopt Medicare Part D's approach which allows for six protected classes

Ms. Davenport concluded her remarks by stating that cancer is not a protected class – we are going to push the panel to seriously consider the issue of formulary. She also offered to provide a report on this issue.

Secretary – thank you – the challenge is to get to a baseline in a timely manner.

Del. Hope – I believe that I already have the answer to my question, it is to find the balance between coverage and affordability – at what point does it become counterproductive – what are the services that if are not covered, what are the costs?

Davenport – many of the provider groups adhere to guidelines; to the extent we can encourage development of guidelines and they are used, along with patient adherence (need incentives); what is the role of prevention in EHB? Virginia has a wonderful opportunity to create incentives to improve health (lose weight, stop smoking) – when you look at diabetes numbers, changes in lifestyle can make dramatic changes

Secretary – use state employee health plan as model, as a value-based plan; can we use these plans in Medicaid, if willing to make the additional expenditure/reinvesting – we are looking at doing things outside of the EHB design

Fralin – in the tiers to be offered, bronze/gold/silver/platinum, can plans offer more than that in the fight to get business? Like wellness. Can they offer a benefit that would enable a seamless transition for Medicaid?

Hunt – the tiers – actuarial value provides what the covered services are and the % paid by the plan

Fralin – so we will be setting the minimum plan of covered services

Hunt – subsidy is tied to the silver plan; you can personally pay more for the gold if you choose

Fralin – if you offer a benefit required by state law, you lose the subsidy to get the benefit by going to gold?

Hunt – do not lose subsidy

Secretary – welcome Sen. Watkins

Dise – We have a commitment to not mess up the plans currently working for small business – for policies (higher deductibles) renewing in 2013 for part of coverage in 2014, are policies that do not meet cost sharing limits of the health care reform going to be taken off the market?

Gray – I don't think so; phased out

Dise – so are those high deductible plans going to be eliminated?

Nichols – yes, they are unlikely to meet health care reform requirements.

Wilson – before we go too far down the road, we need to have serious discussion about tort reform; in every workers comp case at my company, we've had to have MRIs

Secretary – tort reform has a role in this – Virginia has a favorable environment and caps have had an impact on this but there is further room for improvement

Secretary – thanks to the panel; public comment will be at 12:45.

Jones – invited panel to stay after lunch to enhance discussion. Lunch is available for members and staff. The Council will reconvene at 12:45.

Lunch Break

Public comment Period

Secretary- 10 folks have signed up for the opportunity to provide comment today.

Brenda Clarkson, VA Assn for Hospices – statement of mission – comprehensive services cut across most of the 10 EHB categories – usually provided at home and tailored to the patient – palliative care as well - we recommend that hospice be included in EHB; palliative care is not expressly covered, but should be standard of care.

Ray Shure, VA Organizing – followed the initiative since its beginnings, and thank all for the hard work. Commended Sen. Watkins and Del. Hope on HBE legislation. We need to know a lot more about limits of the plans before selecting a benchmark. As a retired Anthem nurse, I understand home health care; when looking at state mandates, please remember they were adopted over a period of years and are important to certain patients. It is important to keep Virginia mandates.

Michael Sizemore, VACSBs – described mission since 1968 – now the opportunity to clearly define mental health services. VACSB has 40 member organizations. Tier I allows consumers to stay in their community, be

employed, attend school; tier II are for more severely impaired individuals to avoid hospitalization (up to 20% in hospitals) reducing from 0-2%

Mira Signer, Virginia Chapter, National Alliance on Mental Illness – an EHB package could reduce hospitalization and speed recovery, decrease institutionalization and incarceration. Echo the need for traditional services, meds and beds, and intensive services to restore functioning, so folks can live in the community like anyone here in this room. Enhanced service will have an impact on costs (reducing hospitalization). Good mental health care is cost effective.

Eddie McCree, Virginia Telehealth – comment on telemedicine in regard to EHB – some misunderstanding of telemed: it is a means of service – VA law requires payment on same basis as face to face; since it provides a way to provide a range of services, including high risk OB, telestroke, rehab, outpatient consults for specialty services in remote areas. Where telemed is widely available, it has significantly reduced low birth weight and lowered cost of direct care and improved outcomes, whether at local hospital or clinic.

Cathy Wiberly – in summary statement of EHB, I would stress importance of telemed in EHB service delivery; the mechanism that brings the exam room to the patient. Barriers to access can be over come. Telemed brings the patient to the physician; brings collective expertise to the bedside.

William Moskewich, VP at VCU Children's Hospital/ President of the Virginia Pediatric Association, recommends that EHB cover all Bright Futures services, or EPSDT; all are medically necessary. Children are not little adults; unique needs/injury not disease. CMS noted that ACA requires EHB provide additional/special services for children. Treating early for childhood illnesses is important for long term health outcomes.

Ashley Chatman, MS society - A large group of Virginia organizations jointly submitted a list of 31 benefits to Bureau of Insurance to ask how the current plans cover them based on plan form filings. It is imperative to have this information before selecting a benchmark plan. EHB benchmark options offer an evaluative tool for considering the needs of chronic disease patients.

End of Comments

VHRI discussion continuation

Secretary – we have scanned through the booklet where the EHB are illustrated to see if we can answer some of the questions raised by speakers.

Fralin – do we want to set forth what the EHB plan is – isn't GA going to do that, just like they were doing in the 2012 session with where the HBE will be housed?

Secretary – there are certain key questions that the GA will want to address; where HBE housed, EHB, etc. We are to make a recommendation, based on information available at this is a point in time

Fralin – what level of detail are we going to get down to?

Secretary – we can narrow it down

Wilson – a speaker made a comment that telemed was a covered service. Not that I'm aware of.

Gray – it's not a covered service, it's a delivery method

Nichols – he's saying that he's not benefited; maybe his company is over 100 employees.

Gray – he has benefited, but telemed is in its infancy

Wilson – an example, an endocrinologist will not get paid for telemed services

Secretary – Perkins can you address?

Perkins – Telemedicine is a covered service. An example is a consultation by a Specialist with a Primary Care Physician and the patient. What telemedicine isn't is any provider who has a webcam and Skypes with a patient. The technology is just not there yet.

Hall – say something to me about the pros and cons of the plan choices

Secretary – Hunt will you start

Hunt – any of the state mandates are automatically covered if you choose one of the small group plans, then the fed cannot make the state pay for those mandates; can't address the question of the largest HMO

Fralin – it is clear when you look at the chart, what's included and what is not, but what about the riders?

Hunt – the cost of those riders would not be eligible for subsidy. The client would pay. If you choose fed or state plan, and state mandates are maintained, then state pays 100% of cost

Nichols – an example, a person considering a policy wants coverage for morbid obesity. If the benchmark was fed, then covered but not with existing small employer plan

Gibson – what about habilitative?

Nichols – not clearly defined, but seems to apply to a very young child. Since it is an EHB, it would not be affected by the mandate/subsidy concern

Task Force member – regarding obesity, would the employer be the one determining whether to cover the rider or is the employee always responsible for the cost?

Nichols – not determined yet because it depends on which plan the VHRI picks. If it's the small employer plan, then it's an employer choice, but if it's the fed plan then it's included.

Secretary – today's plan was to stop at 2:00 but we're far from completing. Could everyone stay until 3:00?

Two members indicated they could only stay until 2:30.

Perkins – its only morbid obesity that's outside of coverage; all others are only a matter of degree

Hall – motion to pick the most inclusive of the small group plans

Perkins - second

Fralin – is that the anthem PPO

Hall – yes

Fralin – there are a lot questions to consider

Secretary – let's walk through the charts and ask questions

Nichols – to Perkins, PPO says 90 visits, HMO nothing?

Perkins – HMO has no limit

Howell – what is non-covered service, not specified; it says not specified for acupuncture, it's not covered?

Perkins – yes, not covered; willing to provide some greater clarification on the PPO coverage

Secretary – do we need to have a subcommittee to meet to clarify some of these issues; would the group approve of appointing a subcommittee to address some of these unanswered questions? – Members concurred

Hall – if we go down the list, look at individual benefits and what's missing and limitations

Hunt – if chosen plan does not cover, and another does, you have to adopt the entire plan structure.

Secretary – it will become a federally subsidized benefit

Howell – morbid obesity is listed as mandate?

Hunt – mandate to offer

Secretary – becomes a rider; moving on to next topic

Perkins – maternity listing is wrong, it is covered

Nichols – we heard a lot today: Chuck, can you give us some clarity

Hall – with serious and persistent mental illness, need to address modality not diagnosis; do involve all the biologic

Nichols – example?

Hall – schizophrenia; hoping that depression will be biologic;

Nichols – today in Virginia, we require coverage of biologic

Gray – Substance abuse is included

Nichols – is anything else?

Gray – Anthem has resolved to treat everyone the same in the small group market

Battle – read from the code on what’s biologic

Secretary – can the committee look at the small group plan and determine that it does not meet fed law and then it becomes federal subsidy?

Hall – parity has only recently passed and industry has not kept up with modalities to treat these types of illnesses

Secretary – is this an insurance coverage issue, or is better funded directly by state

Hall – the former - don’t want to risk putting people in government plan

Secretary – subcommittee will need to look at;

Secretary – prescription drugs, any comment

Gibson – will we develop our own or adopt anthem plan

Gray – not a static benefit;

Hunt – a single formulary in state or left to the individual plan?

Fralin – the question is what drugs are covered; then the issue of cost sharing

Hunt – restriction such as generic only would not apply, but the broad range of coverage does

Secretary – continued to walk through covered benefit categories

Secretary – pediatric prevention, Bright Futures mentioned earlier

Perkins – covered under age 9; preventive and wellness service

Secretary - pediatric oral and vision coverage?

Jones – only plans in VA meet federal requirement – recommendations received were Medicaid’s Smiles for Children v. fed standard.

Secretary – are we smarter to look at one of the HMOs that provide the better platform, e.g., SNF

Hunt – if you choose HMO, costs will be higher; they’ve gotten savings from somewhere else; e.g., smaller network to offer larger benefit

Sen. Watkins - somebody has got to pay for this, question is who; the more benefits, the costlier the plan

Riley – small employer plan is most affordable; leaning toward the Anthem PPO

Kusiak – if we adopt Anthem PPO, Anthem can put on HMO chassis and that can be a competitive edge, correct?

Hunt – yes

Fralin – is it worth describing what the charge of the subcommittee will be?

Secretary – subcommittee to meet and go through the 10 EHB categories and come back with clearer identification of what the benefit means and the gaps

Secretary – depending on how long it takes to answer all the subcommittee questions, it may require another meeting.

Any objections?

Wilson - doesn’t have to be VHRI members only? Want to have Monty and Doug Gray in the group,

Secretary – will invite broader group for the subcommittee. Any objections? Hearing none, the Council concurs.

Secretary – The meeting is adjourned.